



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Mike Yuan, M.D.

Respondent Name

Texas Mutual Insurance Company

MFDR Tracking Number

M4-16-3786-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

August 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = 350.00
Knee IR w/ ROM = 300.00
Nerve IR = 150.00
Total Paid = 650.00
Balance Due = 150.00"

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor, as designated doctor, determined MMI and assigned 0% impairment to the left knee. The requestor also assessed 0% impairment for saphenous nerve neuritis of the left knee and leg. The requestor billed \$800.00 for this with two units of code 99456-W5/WP. Texas Mutual paid \$350.00 for the MMI exam and \$300.00 for the IR exam.

The requestor argues an additional \$150.00 is due for the saphenous nerve assessment because in its request for reconsideration the requestor states, '... each additional musculoskeletal body area is \$150.00.' However, the left lower extremity, a musculoskeletal body area, cannot be assessed twice for impairment. There is only one impairment per musculoskeletal body area though there may be several different clinical reasons for it."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 22, 2016	Designated Doctor Examination	\$150.00	\$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - CAC-P12 – Workers’ compensation jurisdictional fee schedule adjustment.
 - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
 - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
 - 724 – No additional payment after a reconsideration of services.

Issues

1. What is the maximum allowable reimbursement (MAR) for the disputed services?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.204(j)(3), “The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350.” The submitted documentation supports that the requestor performed an evaluation of Maximum Medical Improvement. Therefore, the correct MAR for this examination is \$350.00.

Per 28 Texas Administrative Code §134.204(j)(4):

- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
 - (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis;
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
 - (ii) The MAR for musculoskeletal body areas shall be as follows.
 - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
 - (II) If full physical evaluation, with range of motion, is performed:
 - (-a-) \$300 for the first musculoskeletal body area; and
 - (-b-) \$150 for each additional musculoskeletal body area.
- (D) ...
 - (i) Non-musculoskeletal body areas are defined as follows:
 - (I) body systems;
 - (II) body structures (including skin); and,
 - (III) mental and behavioral disorders.
 - (ii) **For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides [emphasis added]...**
 - (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that the requestor performed impairment rating evaluations of a left knee strain and Saphenous nerve neuritis. Documentation supports that the requestor performed a full physical evaluation with range of motion for the left knee. The MAR for this examination is \$300.00.

The insurance carrier argues that the Saphenous nerve assessment is part of the left lower extremity examination as part of the musculoskeletal category. Page 5 of the Designated Doctor report finds that the requestor referenced the “4th Edition AMA Guides to the Evaluation of Permanent Impairment, Chapter 4, The Nervous System,” when making the assessment for the Saphenous nerve. The nervous system is considered a body system in the non-musculoskeletal category, regardless of the specific location in the body. Therefore, the correct MAR for this examination is \$150.00.

2. The total MAR for the disputed services is \$800.00. The insurance carrier paid \$650.00. An additional reimbursement of \$150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	Laurie Garnes	September 28, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.